

Long-Term Care Hospital Prospective Payment System



What Is an Interrupted Stay?

An interrupted stay occurs when a Long-Term Care Hospital (LTCH) patient is discharged from an LTCH (for treatment and services that are not available in the LTCH) and after a specific number of days away from the LTCH, is readmitted to the same LTCH for further medical treatment. The original interrupted stay policy, established at the start of the LTCH Prospective Payment System (PPS), for cost reporting periods beginning on or after October 1, 2002, addressed a situation where a patient discharged from an LTCH is directly admitted to a specific type of Medicare provider [an inpatient acute care hospital, an Inpatient Rehabilitation Facility (IRF), or Skilled Nursing Facility (SNF)/swing bed], and then returns to the original LTCH within a specified period of time. This specified period of time, also called a fixed-day period, varies depending on the type of facility that receives the patient from the LTCH.

Are There Different Types of Interrupted Stays?

In the May 7, 2004 Final Rule for the LTCH PPS, the Centers for Medicare & Medicaid Services (CMS) revised the interrupted stay policy, effective July 1, 2004, to include a discharge and readmission to the original LTCH within 3 days, regardless of where the patient goes upon discharge. This revision implemented two components to the interrupted stay policy: the original policy (called the "greater than 3-day interruption of stay") and the expansion of this policy (the "3-day or less interruption of stay"). If a stay falls within either definition, Medicare will pay only one Long-Term Care-Diagnosis Related Group (LTC-DRG) payment to the LTCH.

Background

Long-Term Care Hospitals (LTCHs) treat patients with multi-comorbidities requiring long-stay hospital-level care. To be designated as an LTCH, Medicare requires that a hospital typically demonstrates that on average, it has an average length of stay for its Medicare patients of greater than 25 days. The Balanced Budget Refinement Act of 1999 (BBRA) mandated a new discharge-based prospective payment system for LTCHs. The Long-Term Care Hospital Prospective Payment System (LTCH PPS) replaced the previous cost-based system. Congress provided further requirements for the LTCH PPS in the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvements and Protection Act of 2000 (BIPA).

What Are Long-Term Care-Diagnosis Related Groups?

The LTCH PPS uses Long-Term Care-Diagnosis Related Groups (LTC-DRGs) as a patient classification system. Each patient stay is grouped into an LTC-DRG based on diagnoses (including secondary diagnoses), procedures performed, age, gender, and discharge status. Each LTC-DRG has a pre-determined Average Length of Stay (ALOS), or the typical Length of Stay (LOS) for a patient classified to the LTC-DRG. Under the LTCH PPS, an LTCH receives payment for each Medicare patient, based on the LTC-DRG to which that patient's stay is grouped. This grouping reflects the typical resources used for treating such a patient. Cases assigned to an LTC-DRG are paid according to the Federal payment rate, including adjustments. One type of case-level adjustment is an interrupted stay.

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What Is the “3-day or Less Interruption of Stay” Policy?

This policy covers LTCH discharges and readmissions to the same LTCH within 3 days. During that time, the patient may have received outpatient or inpatient tests, treatment, or care at an acute care hospital, an IRF, or a SNF/swing bed, or there may have been an intervening patient-stay at home for up to 3 days without the delivery of additional tests, treatment, or care.

If the interruption exceeds 3 days, LTCH payment will be determined under the original interrupted stay policy (referred to as a “greater than 3-day interruption of stay”), but the day count for purposes of determining the length of the stay away from the LTCH begins on the day that the patient is first discharged from the LTCH. Medicare payment for any test, procedure, or care provided to the patient on either an outpatient or inpatient basis during the “interruption” would be the responsibility of the LTCH “under arrangements.” This policy is discussed in greater detail in the rest of this Fact Sheet.

What Is the “Greater than 3-day Interruption of Stay” Policy?

If a patient who has been discharged from an LTCH and admitted to an acute care hospital, an IRF, or a SNF/swing bed, is readmitted to the same LTCH after 3 days, the original interrupted stay policy (called the “greater than 3-day interruption of stay” policy) governs. The following table lists the fixed-day periods for each type of facility:

Facility Type	Fixed-Day Period
Inpatient Acute Care Hospital	Between 4 and 9 days
Inpatient Rehabilitation Facility	Between 4 and 27 days
Skilled Nursing Facility/Swing Bed	Between 4 and 45 days

To meet the full definition of a “greater than 3-day interruption of stay,” the patient must also be:

- Discharged directly from the LTCH and admitted directly to an inpatient acute care hospital, an IRF, or a SNF/swing bed.

AND

- Discharged back to the original LTCH after a Length of Stay (LOS) that falls within the applicable fixed-day period.

If the patient's hospitalization at an acute care hospital, an IRF, or a SNF/swing bed falls respectively within the 9, 27, or 45 day threshold, when the patient is readmitted to the LTCH, the entire stay is considered an interrupted stay and one LTC-DRG payment will be made based on the initial admission. The day count to determine whether or not a patient has been away from the LTCH for purposes of the “greater than 3-day interruption of stay” policy begins on the day of discharge and continues until the day of readmission, even though this policy governs beginning on the patient's fourth day away from the LTCH. A case may have multiple interrupted stays, but each stay must be evaluated separately to make certain that it meets the interrupted stay criteria. Cases with interrupted stays may also be eligible for other case-level adjustments (for example, the case may also be eligible for a short-stay outlier payment).

Under both interrupted stay policies, Medicare will make a separate payment to the intervening provider (i.e., the acute care hospital, the IRF, or the SNF/swing bed), if the interruption in the LTCH stay exceeds 3 days and the patient stay is governed by the “greater than 3-day interruption of stay” policy. Similarly, if the interruption in the LTCH stay exceeds the fixed-day thresholds, the readmission to the LTCH will be treated as a separate LTCH stay and Medicare will make an additional payment to the LTCH when the patient is discharged from the LTCH.

What Are Some Examples of Cases Governed Under the “3-day or Less Interruption of Stay” Policy?

The following examples describe scenarios that would be governed under the “3-day or less interruption of stay” policy:

Example 1:

An LTCH patient is discharged from an LTCH on a Monday (Day 1) and is immediately admitted to an acute care hospital. On Tuesday (Day 2), the patient is released from the acute care hospital and returns home. On Wednesday (Day 3), the patient is readmitted to the original LTCH. The patient is discharged from the LTCH four weeks later. In this case, Medicare will pay for the entire stay, including the interruption, with one LTC-DRG payment, which will be determined based upon the patient's entire medical record, including diagnoses and treatment during the intervening hospitalization at the acute care hospital on Day 2 of the interruption. The LTCH will be responsible for paying the acute care hospital for the patient stay on Day 2 “under arrangements.”

Example 2:

An LTCH patient is discharged home on Monday (Day 1). On Tuesday (Day 2), the patient receives outpatient diagnostic tests at an acute care hospital. On Wednesday (Day 3), the patient is readmitted to the original LTCH and remains an additional 10 days. In this case, one Medicare payment will be made to the LTCH (and depending upon the entire LOS, it could be a short stay outlier payment), and the LTCH will be responsible for paying the outpatient services received on Day 2 during the interruption.

Example 3:

An LTCH patient is discharged on Day 1 to an acute care hospital for an appendectomy and returns to the original LTCH the next day for a resumption of the original treatment, as well as post-operative care, with a discharge occurring 30 days later. In this case, for discharges on or after July 1, 2006, Medicare will pay only one LTC-DRG payment to the LTCH and the LTCH will be responsible for costs of the appendectomy. (Please see the section of this Fact Sheet titled, “How Is Payment Made for Services Rendered During a 3-day or Less ‘Interruption’?” for more information on the policy for surgical DRG payments.)

Example 4:

An LTCH patient is discharged on Day 1 to a SNF. On Day 2, the patient is admitted and stays overnight at an acute care hospital following treatment in its emergency room. On Day 3, the patient is readmitted to the original LTCH. Medicare will pay only one LTC-DRG payment to the LTCH, and the LTCH will be responsible for costs of all care and treatment obtained by that patient during the 3-day interruption. (Please see the section of this Fact Sheet titled, “How Is Payment Made for Services Rendered During a 3-day or Less ‘Interruption’?” for more information on the policy for discharges and re-admittances during a 3-day or less interrupted stay.)

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If in any one of these cases, the patient remained away from the LTCH for more than 3 days, Medicare payment will be made under the original or “greater than 3-day interruption of stay” policy.

What Is Not an Interrupted Stay?

The following examples are not interrupted stays under the “greater than 3-day interrupted stay” policy:

- The patient has an LOS at the receiving facility (an acute care inpatient hospital, an IRF, or a SNF/swing bed) that exceeds the fixed-day period for the facility type.

Example:

A patient is discharged from the LTCH and then is admitted to an acute care hospital. The patient then returns to the same LTCH after 10 or more days. The return to the LTCH is a new admission.

- The patient is discharged to a type of facility other than the four types of facilities previously mentioned.

Example:

A patient is discharged from the LTCH and then is admitted to care provided by a home healthcare agency. The return to the original LTCH is a new admission.

- The patient is discharged to more than one facility.

Example:

A patient is discharged from the LTCH, is admitted to an IRF, and then is discharged from the IRF to an acute care hospital. Finally, the acute care hospital discharges the patient to the original LTCH. The return to the LTCH is a new admission.

- The patient returns home between LTCH stays for more than three days.

In all of these scenarios, if a stay disruption does not meet the definition for an interrupted stay, the original discharge ends the patient's first stay. If the patient is readmitted to the facility, the second admission begins a new stay. The LTCH would receive two LTC-DRG payments for two patient stays: one payment for the first stay, and a separate payment for the stay after the readmission to the LTCH.

If the patient's stay meets the interrupted stay criteria, the principal diagnosis should not be changed when the patient returns to the LTCH from the receiving facility. If other medical conditions are apparent upon the patient's return to the LTCH, the additional diagnosis codes should be noted on the claim.

Final Rules That Affect the LTCH PPS

CMS published six Final Rules affecting Medicare payments to LTCHs on the following dates:

May 7, 2004 - the 2005 Rate Year (RY) Final Rule was published, increasing the Medicare payment rates for LTCHs, expanding the existing interrupted stay policy, finalizing the requirements for a satellite or remote location to qualify as an LTCH, and changing the ALOS calculation for LTCH status.

December 30, 2004 - the Fiscal Year (FY) 2005 IPPS Final Rule was published, containing a number of provisions contained in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

May 6, 2005 - the RY 2006 Final Rule was published, updating the annual payment rates effective July 1, 2005. In addition to revising the wage index, outlier fixed loss amount and the budget neutrality factor, the Final Rule also clarified the notification policy for co-located LTCHs and satellites of LTCHs and adopted new labor market area definitions based on Core-Based Statistical Areas (CBSAs).

August 12, 2005 - The FY 2006 IPPS Final Rule was published, containing the LTC-DRGs, relative weights, and the ALOS for FY 2006.

May 12, 2006 - the RY 2007 Final Rule was published, updating the LTCH PPS payment rates, effective July 1, 2006. In addition, the Final Rule also revised the Short-Stay Outlier policy and removed the 3-day surgical exception to the Interrupted Stay policy.

August 18, 2006 - the FY 2007 IPPS Final Rule was published, which included revisions to the methodology for determining the LTCH PPS CCR ceiling and applicable statewide average CCRs, as well as clarification and codification of the existing policy regarding LTCHs' CCRs and the reconciliation of outlier payments.

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There are no current separate policy provisions regarding transfers between LTCHs. The admissions to each LTCH are treated as separate cases. CMS will be monitoring such discharges.

How Are Days Counted Under the Interrupted Stay Policy?

The interrupted stay day count begins on the day of discharge from the LTCH and continues until the 9th, 27th, or 45th day after the discharge (depending on the facility type). Though the “greater than 3-day interruption of stay” policy governs from the fourth day forward, the day count of the interruption begins on the first day that the patient is away from the LTCH. If an interruption in the patient’s stay at an LTCH meets the interrupted stay criteria, the days prior to the original discharge from the LTCH will be added to the number of days following the readmission at the receiving Medicare provider. The days before and after an interrupted stay determine the total LOS for the episode of care. If the patient is discharged home and returns to the LTCH within 3 days without having received any additional medical treatment, the days away from the LTCH will not be included in the total LOS. However, if treatment is received on any of the 3 days (for which the LTCH is responsible for “under arrangements”), the days must then be counted in the total LOS for that patient.

An example of how days are counted under the Interrupted Stay policy is shown below:

A patient is admitted to an LTCH on Day 1 and discharged to an acute care hospital on Day 8. The patient returns to the original LTCH on Day 14. Since the time between the discharge to the acute care hospital and the return to the LTCH is 7 days, the stay meets the fixed-day period requirement for acute care hospitals. This example is an interrupted stay case for the LTCH. The first 8 days of the LTCH stay (Day 1 through Day 8) will be added to the day count of the second portion of the LTCH stay. Depending on the accumulated LOS, the LTCH will receive either a short-stay outlier payment or a full LTC-DRG payment for the case. (The acute care hospital will receive a separate payment from Medicare for this case.)

How Is Payment Made for Services Rendered During a 3-day or Less “Interruption”?

Medicare payments for any test, procedure, or care provided to an LTCH patient on an outpatient basis or for any inpatient treatment during the “interruption” would be the responsibility of the LTCH “under arrangements.”

Therefore, any tests or procedures that were administered to the patient during that period of time, including, as of July 1, 2006, inpatient surgical care at an acute care hospital, will be considered part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability. If any tests or procedures are delivered any time during the 3-day interruption (with payment being made by the LTCH to the intervening provider “under arrangements”), all days of the interruption will be included in the total day count for that patient. If no care is provided during the interruption, the days away from the LTCH are not included in the patient stay.

The LTCH PPS Final Rule, published on May 12, 2006, discontinued the surgical DRG exception to the 3-day or less Interrupted Stay policy for discharges on or after July 1, 2006. This policy had allowed Medicare to make a separate payment to an acute care hospital if the patient’s condition was grouped to a surgical DRG during the interruption in stay. With the policy discontinuation, the LTCH would be required to provide such services “under arrangements” (i.e., the LTCH would pay the acute care hospital for the services). Medicare would not make a separate payment to the acute care hospital.

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How Are Interrupted Stay Payments Determined?

Unlike other case-level adjustments, billing instructions determine payment for interrupted stays. Interrupted stay payments (which, if applicable, may also be impacted by the co-location policy discussed in the next section) are determined by the Fiscal Intermediary at the cost report settlement.

Are There Any Special Policies for Co-Located Providers?

If an LTCH is onsite (co-located) with another Medicare provider (for example, a hospital-within-a-hospital or a satellite of an LTCH that is co-located with another provider), a special interrupted stay payment policy may apply to LTCH patient discharges between the co-located facilities. CMS created this special payment policy to discourage unnecessary patient shifting between providers that share a physical location. Under the policy, if the number of discharges and readmissions between an LTCH and a co-located provider exceeds 5% of the total discharges during a cost reporting period, only one LTC-DRG payment will be payable to the LTCH for all such discharges and readmissions. This payment policy applies to discharges before and after the threshold is exceeded. There are two distinct 5% thresholds, as shown in the following tables:



Co-Located Provider Policy For Onsite Acute Care Hospitals	
If...	Then...
During a cost reporting period, an LTCH readmits more than 5% of its patients who were discharged to an onsite acute care hospital...	The LTCH receives only one LTC-DRG payment for all such discharges during the cost reporting period once the 5% threshold is met. This includes all cases prior to, and after, the threshold has been surpassed for that cost reporting period.
Co-Located Provider Policy For Onsite IRF, SNF/Swing Bed, or Psychiatric Facilities	
If...	Then...
During a cost reporting period, an LTCH readmits more than 5% of its patients who were discharged to an onsite IRF, SNF/swing bed, or psychiatric facility (or any combination of the above)...	The LTCH receives only one LTC-DRG payment for all such discharges during the cost reporting period once the 5% threshold is met. This includes all cases prior to, and after, the threshold has been surpassed for that cost reporting period.

Providers are required to inform their Fiscal Intermediary and their CMS Regional Office about any change in co-location status by providing, in writing, the name(s), address(es), and Medicare provider number(s) of co-located providers.

What Are the Requirements for Satellite or Remote Locations to Qualify as an LTCH?

In the May 7, 2004 LTCH PPS Final Rule, CMS finalized its clarification of the requirements for a satellite or remote location to qualify as an LTCH. Generally, where a satellite of an LTCH is separating from a parent LTCH, the facility must first be separately certified as a hospital (e.g., an acute care hospital) and then present the hospital's discharge data collected after it was separately certified to show that it has met the Average Length of Stay (ALOS) requirement for 5 of the 6 months following certification. If the separation is required by the provider-based regulations, the hospital may submit ALOS data for the satellite or remote location from the 6-month period preceding the separation for purposes of qualifying for payment under the LTCH PPS.

Where Can I Find More Information about the LTCH PPS?

The following online references provide more information about the LTCH PPS:

- The Medicare Learning Network Web Page
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at www.cms.hhs.gov/MLNGenInfo on the CMS website.
- Long-Term Care Prospective Payment System Web Page
www.cms.hhs.gov/LongTermCareHospitalPPS/01_Overview.asp
The Long-Term Care Hospital Web Page provides the Final Rules and additional LTCH PPS-related documents.
- LTCH PPS Press Release Updating the LTCH PPS for Rate Year 2007
www.cms.hhs.gov/apps/media/press/release.asp?Counter=1848
The press release summarizes how Medicare is updating the format and data of the LTCH PPS system for Rate Year 2007. These changes were also published in the Federal Register on May 12, 2006.
- LTCH PPS Final Rule on Annual Payment Rate Updates and Policy Changes
www.cms.hhs.gov/QuarterlyProviderUpdates/Downloads/CMS1485F.pdf
The LTCH PPS Final Rule provides a more in-depth look at the changes for Rate Year 2007.
- Federal Register Notice for Revision to Hospital Inpatient Prospective Payment System (IPPS) FY 2007 Final Rule (CMS-1488-F)
www.cms.hhs.gov/QuarterlyProviderUpdates/Downloads/CMS1488F.pdf
The FY 2007 IPPS Final Rule establishes changes to the methodology for determining the CCR ceiling and applicable statewide average CCRs used under the LTCH PPS, as well as clarification and codification of existing policy regarding the determination of LTCHs' CCRs and the reconciliation of LTCH PPS outlier payments. This Final Rule also contains the LTC-DRGs, relative weights, ALOS, and other IPPS-excluded hospital policy changes that are effective October 1, 2006, under the LTCH PPS.
- CMS Manual System - Medicare Claims Processing Manual - Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2007 (Transmittal 981)
www.cms.hhs.gov/transmittals/downloads/R981CP.pdf
The CMS Manual System - Medicare Claims Processing Manual update provides updated payment rates, provisions, and updates to the Medicare Claims Processing Manual for the LTCH PPS Rate Year 2007.

Questions about interrupted stays and the LTCH PPS can be emailed to ltchpps@cms.hhs.gov.

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Where Can I Find More Information about ICD-9-CM Coding?

The LTCH PPS Final Rule emphasized that proper coding is essential for correct diagnosis and procedure reporting. The following online references provide ICD-9-CM coding guidance:

- The ICD-9-CM Official Guidelines for Coding and Reporting

www.cdc.gov/nchs/data/icd9/icdguide.pdf

The LTCH PPS Final Rule stated that the *ICD-9-CM Official Guidelines for Coding and Reporting* is essential reading for understanding how to report the proper diagnosis and procedure codes that are used in determining the LTC-DRG payment amounts.

- Updates to the ICD-9-CM Diagnosis and Procedure Codes

www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/

This website identifies the activities (including public meeting schedules and agendas) of the ICD-9-CM Coordination and Maintenance Committee charged with maintaining and updating the ICD-9-CM coding system.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.